Heavenly Hands Mobile Massage

CONSULTATION FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? **Yes** ☐ **No** ☐

MEDICAL HISTORY

Please check any conditions below that applies to you:

- ☐ Arthritis / joint disorder
- ☐ Artificial joint
- ☐ Atherosclerosis
- ☐ Blood disorder
- ☐ Back/neck problems
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Circulatory disorder
- ☐ Contagious skin condition
- ☐ Decreased sensation
- ☐ Deep vein thrombosis/blood clots
- ☐ Diabetes
- ☐ Easy bruising
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Fibromyalgia
- ☐ Headaches/migraines
- ☐ Heart condition
- ☐ High/low blood pressure
- ☐ Immune disorders
- ☐ Keloid scarring
- ☐ Open sores or wounds
- ☐ Osteoporosis
- ☐ Phlebitis, blood clots
- ☐ Pregnant
- ☐ Recent accident or injury
- ☐ Recent fracture
- ☐ Seborrhea
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Sprains/strains
- ☐ Swollen glands
- ☐ Tennis elbow
- ☐ TMJ
- ☐ Varicose veins

Please explain any condition that you have marked above: _____

_____

Any other condition? ☐ No ☐ Yes: _____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____

MASSAGE INFORMATION

Have you had a professional massage before? ☐ No ☐ Yes

Do you have sensitive skin? ☐ No ☐ Yes

What is your occupation? _____

Do you have any difficulty lying on your front, back, or side? ☐ No ☐ Yes: _____

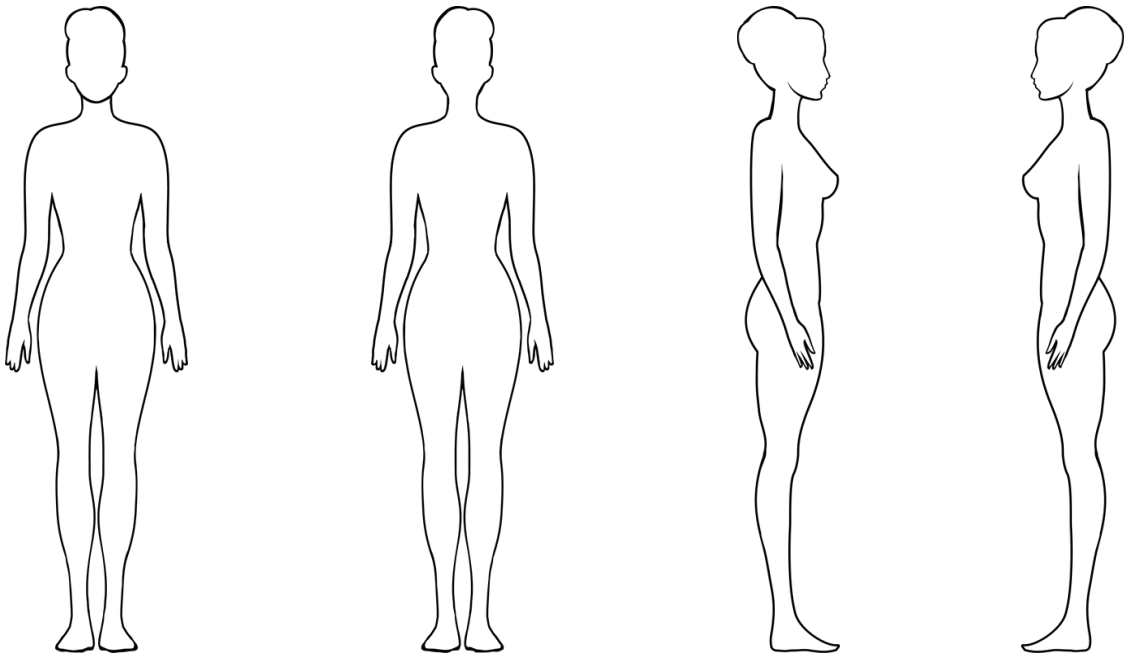
Do you have any allergies to oils, lotions, or ointments? ☐ No ☐ Yes: _____

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen) you do not want massaged? _____

Mark any specific areas you would like your therapist to concentrate on:



Front Back Right Left

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name (printed) :

Client Name (signature) : Date:

MASSAGE INFORMATION

Have you had a professional massage before? ☐ No ☐ Yes

Do you have sensitive skin? ☐ No ☐ Yes

What is your occupation? _____

Do you have any difficulty lying on your front, back, or side? ☐ No ☐ Yes: _____

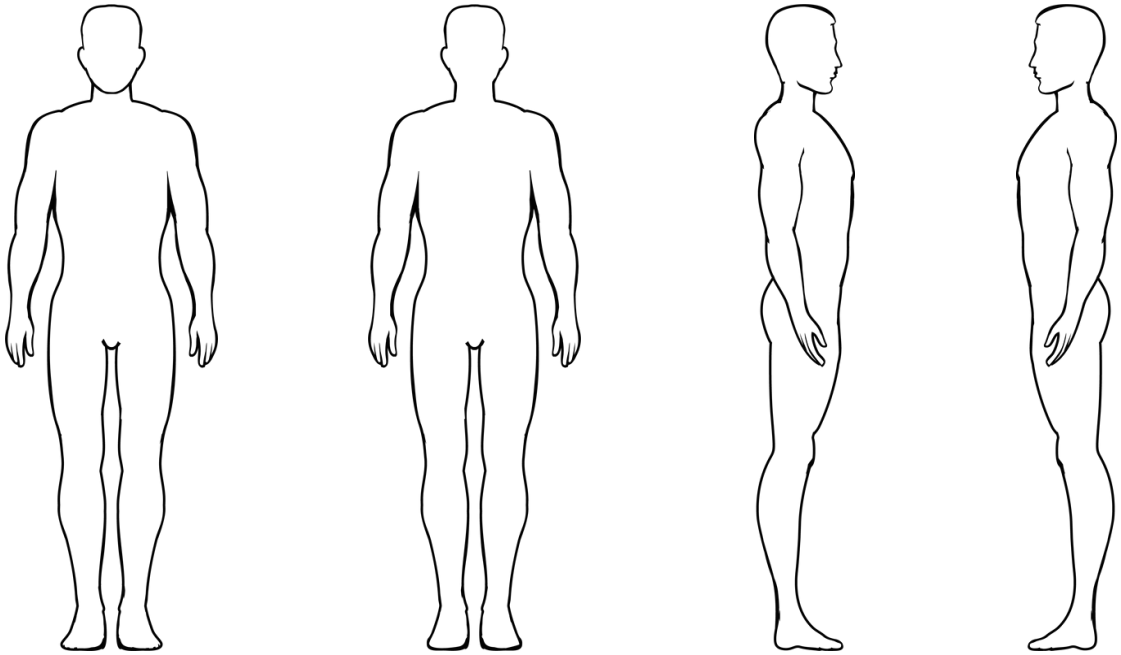
Do you have any allergies to oils, lotions, or ointments? ☐ No ☐ Yes: _____

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/deep tissue

What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Are there any areas (feet, face, abdomen) you do not want massaged? _____

Mark any specific areas you would like your therapist to concentrate on:



Front Back Right Left

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name (printed) :

Client Name (signature) : Date: